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Why WHO needs a feminist economic agenda



Mark Henley/Panos Pictures

In September, 2019, Alan Donnelly and Ilona Kickbusch called for a chief economist at WHO.¹ Such a position, they argued, would enable WHO to better advocate for greater recognition of, and thus action on, the interdependency of health and the economy. We support this proposal: recognition of the interdependence of health and the economy is vital for WHO to achieve its mandate: “the enjoyment of the highest attainable standard of health... without distinction of race, religion, political belief, economic or social condition”.² Given this mandate, WHO should be more ambitious than the appointment of one economist. A more strategic and enlightened approach, especially in the aftermath of the coronavirus disease 2019 (COVID-19) pandemic,³ would be for WHO to embrace and articulate a feminist economic agenda.

A feminist economic agenda interrogates power dynamics and peoples’ relative access to and use of wealth and resources. A feminist economic lens that incorporates intersectionality must address the power dynamics between genders and acknowledge the power relationships between nation states, ethnicities, ages, abilities, and other dimensions of diversity, and how they are interconnected with gender inequality and the economy.⁴

A feminist economic approach is consistent with how public health is taught and sometimes practised: that health, and access to health care, is interdependent not only on the economy but also on all other social and commercial determinants of health.^{5,6}

WHO has estimated a shortfall of 18 million health workers by 2030, largely in low-income and middle-income

countries. Women comprise more than 70% of the global health workforce, but WHO research into the state of gender equity in the health workforce has revealed systematic gender biases, inequities, and discrimination.⁷ A feminist economic approach recognises the systems of disadvantage and discrimination that lead to this inequality. Minority ethnic status, class, education, and sexuality determine who is represented in unpaid community health-care worker roles.⁸ The unpaid and low paid labour of women has contributed to profits for private health-care providers and saved the bottom line of health spending in national budgets: capitalism and patriarchy combine to systematically undervalue social reproductive labour—ie, unpaid care roles as women’s work.⁹

Governments’ ability to fund health-care services is dictated by their revenue and fiscal policy space. For the world’s poorest countries, revenue and fiscal space have been largely controlled by the policy advice and loan conditionalities of international financial institutions such as the International Monetary Fund (IMF) and the World Bank. The IMF,¹⁰ the World Bank,¹¹ the G7,¹² and the G20¹³ have championed gender equality, while the G7 and G20 have highlighted the necessity of universal health coverage (UHC) and the World Bank aims to support pandemic response through its Pandemic Emergency Financing Facility. Yet the IMF and the World Bank continue to prioritise austerity measures and “private sector first” strategies that systematically undermine the ability of governments to provide public services and achieve UHC.^{14,15} Neither institution has linked its rhetoric

on promotion of gender equality to the development of a systematic approach for evaluating the implications of its austerity policies on gender inequality, health delivery, or outcomes.^{16,17}

The key funders of the IMF and the World Bank, and those that hold the greatest number of Executive Board votes, are G7 and G20 members. These blocs comprise nations (Canada, France, Sweden, Australia, and the UK) with domestic UHC and feminist or gender-focused development policies, although not without their criticisms.¹⁸ These same countries also fund the international financial institutions that promote austerity policies that reduce public spending on health services and wages.^{14,15}

The world's health care is largely delivered by women, but most decision making, including national budgets, lies in the hands of men.⁷ Initiatives such as Women in Global Health and Women Leaders in Global Health have raised the importance of increasing the numbers of women in health decision-making roles and institutions. However, undertaking a feminist analysis of health delivery and resourcing is not gender specific—men can be feminists, and not all women will be. A feminist economic approach to health requires that all people at all levels of health-care decision making reorient their notion of wellbeing to include gender equality for women in all their diversities.¹⁹ Feminist knowledge informs what we count as costs and savings: the national income saved from women's low wages or volunteerism as health-care workers;²⁰ the benefit to national budgets and health outcomes when there are gender-based violence health-care prevention programmes;²¹ and the negative burdens carried by health-care workers exposed to violence, harassment, and exploitation when their work is located in unregulated environments, including homes, non-governmental organisations, and provincial health clinics.²²

A WHO economic engagement strategy that does not address the social and political determinants of health delivery, resourcing, and decision making risks perpetuating the falsehood that health is a technical enterprise that can be achieved in a silo. Health programmes that ignore gender, race, human rights, capitalism and corporatism, sovereign debt, donor influence, (neo)colonialism, and post-conflict transitions will fail to advocate for the necessary political economic interventions that underpin effective health delivery and outcomes.

The question remains whether a feminist economic agenda led by WHO would hold sway over decision makers in governments, political blocs, and international financial institutions. The answer lies in political momentum and WHO's knowledge of the social and commercial determinants of health.

As international financial institutions and donor groups like the World Bank and the Organisation for Economic Co-operation and Development embrace gender equality and the UHC agenda, WHO has the opportunity to use its access to these institutions to demonstrate the necessity of a feminist economic approach to build better, more equitable ways to steer sustainable economies that prioritise health and gender equality as mutually inclusive.

We declare no competing interests.

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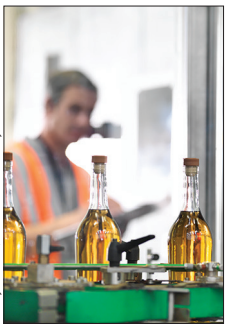
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Reduction in global alcohol-attributable harm unlikely after setback at WHO Executive Board



Monty Rakusen/Science Photo Library

A decision emerged after many hours of informal consultation at the WHO Executive Board in February, 2020, on the next steps for global governance of harmful use of alcohol. Clear evidence of increased alcohol consumption and attributable harm in many low-income and middle-income countries (LMICs),¹ and predictions of more harm to come if effective policy is not adopted,² led a group of representatives from LMICs to propose a working group “to review and propose the feasibility of developing an international instrument for alcohol control”.³ The outcome⁴ of the Executive Board discussion illustrates the difficulty that alcohol control advocates face in the global governance environment; it is a compromise that might do more harm than good.

The call for a working party to investigate an international control mechanism is not part of the final decision. Instead there is a decision to develop an action plan (2022–30) “to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority” and for a review of the global strategy by 2030.⁴ This outcome gives the transnational alcohol corporations another 10 years to expand their markets in LMICs with emerging economies, the very countries that have been calling for investigation of a health treaty on alcohol, similar to that on tobacco, for several years.⁵

In these next 10 years, the alcohol industry will benefit from the existing and future economic agreements, the effect of which is to chill the uptake of alcohol policies.⁶ Without a framework convention, industry is expected to continue its unregulated marketing in the digital world, using big data to identify and target potential and current alcohol users,⁷ and increase profits. Lobbying by

industry and associated stakeholders is likely to prevent the uptake of effective policy.⁸

If we are to prevent the increase in alcohol-attributable harm in the emerging markets, the global health community needs to support national health sectors to protect abstention and reduce the extent to which alcohol is consumed in heavy drinking occasions. We need analysis to develop the content of an international control mechanism to support national governments and attract funding as the WHO Framework Convention on Tobacco Control (FCTC) has done.^{9,10} In this context, we question the Executive Board decision. How can the governing body of an evidence-based health-protection organisation not investigate the feasibility of an international response that is so clearly needed? Perhaps the answer lies in the alcohol blind spot,¹¹ a failure to respond to alcohol harm by the global health community, and behind that the profits made by the alcohol transnational corporations.

Industry-funded organisations were engaged in the lead-up to the Executive Board discussion.¹² Engaging America’s Global Leadership argued: “The Global Strategy has so far been effective and should remain the leading international policy instrument to reduce harmful drinking...Despite the constructive progress that has been made, WHO EB documents have instead started to emphasize that reducing alcohol consumption is an unmet goal, pushing for members to adopt and expand the use of ‘best buys’ policies. These policies—tax increases on alcohol, restrictions on alcohol marketing, and limitations on the physical availability of retail alcohol—have unverified track records and can cause serious unintended consequences.”¹³